

**Authorization For Consent To Medical Treatment
For A Minor Child**

Purpose: to provide medical or surgical treatment for your child in the event we are unable to contact you. Please complete the form and leave it with the person(s) supervising your child.

I (we) _____
Name(s)

Of _____
City County State

Do hereby state that I am (we are) the parent(s)/guardian(s) having legal custody

Of _____, M/F _____, a minor, _____, born _____
Child's Name Sex Age Birth Date

Who resides with me(us) at _____
Address

I (we) authorize the **Lifeline Youth Group leader**, an adult representing **Praise Christian Fellowship**, in the City of Pleasant Valley, County of Litchfield, State of Connecticut, to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to the minor, at a recognized medical facility, under the general or special supervision of a licensed physician or surgeon.

Dated this _____ day of _____ 200__ Notary Seal Here

Signature of Parent(s) or Guardian(s) Notary's Signature

This authorization will expire on ____/____/____
Date Date

Witness _____
Signature Date

Existing Medical Problems of Child, Yes No if yes, explain _____

Physical Limitations of Child, Yes No if yes, explain _____

Allergies, Yes No if yes, explain _____

List all applicable: Child's Doctor _____ Phone # _____
Name

Specialist(s) _____ Phone # _____

Medications if any _____

Health Insurance Co. _____ Policy# _____
Name

Last Tetanus shot date _____

Parent(s)/Guardian(s) phone # _____
Home Work Beeper

Alternate contact _____
Name Phone#